FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038281

Facility Name: HERITAGE MANOR-NORMAL

Address: 509 N. ADELAIDE (Number) NORMAL (City) 61701 (Zip Code)

County: MCLEAN

Telephone Number: (309) 452-7468 **Fax #** ( )

IDPA ID Number: 370909086004

Date of Initial License for Current Owners: 04/01/79

Type of Ownership:

	VOLUNTARY,NON-PROFIT	xx	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		xx	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name craig ater **Telephone Number:** (309)823-7135

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) CRAIG L. ATER
(Title) SENIOR V.P. FINANCE

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

DPA 3745 (N-4-99)

IL478-2471

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Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	164	Skilled (SNF)	164	60,024	1
2		Skilled Pediatric (SNF/PED)			2
3	0	Intermediate (ICF)	0	0	3
4		Intermediate/DD			4
5		Sheltered Care (SC)		0	5
6		ICF/DD 16 or Less			6
7	164	TOTALS	164	60,024	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	21,215	23,148	1,476	45,839	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	0	0	0		12
13	DD 16 OR LESS					13
14	TOTALS	21,215	23,148	1,476	45,839	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 76.37%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [XX]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [XX]

I. On what date did you start providing long term care at this location?
Date started 1979

J. Was the facility purchased or leased after January 1, 1978?
YES [xx] Date _____ NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [XX] NO [ ] If YES, enter number of beds certified 1979 and days of care provided _____

Medicare Intermediary MUTUAL OF OHMAHA

IV. ACCOUNTING BASIS

ACCRUAL [XX] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [XX] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

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	G/L	RECAP CENSUS	DIFF
PP	27111	27111	0
IPA	21215	21215	0
medicare	1476	1476	0
	49802	49802	

IPA BEDHOLDS	0
PP BEDHOLDS	211
PP CONVERS	3752

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	271,101	21,113		292,214		292,214	3,984	296,198			1
2	Food Purchase		175,700		175,700		175,700	(1,027)	174,673			2
3	Housekeeping	96,039	31,658		127,697		127,697	0	127,697			3
4	Laundry	94,038	36,074		130,112		130,112	0	130,112			4
5	Heat and Other Utilities			115,251	115,251		115,251	1,388	116,639			5
6	Maintenance	114,675	64,579	31,536	210,790		210,790	14,098	224,888			6
7	Other (specify):*							0				7
8	TOTAL General Services	575,853	329,124	146,787	1,051,764		1,051,764	18,443	1,070,207			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000	0	3,000			9
10	Nursing and Medical Records	1,629,430	83,429	37,757	1,750,616		1,750,616	0	1,750,616			10
10a	Therapy		161,558	113,679	275,237	(353,592)	(78,355)	185,420	107,065			10a
11	Activities	43,965	5,168	0	49,133		49,133	0	49,133			11
12	Social Services	50,825	0	827	51,652		51,652	0	51,652			12
13	Nurse Aide Training	2,862	1,284		4,146		4,146	3,475	7,621			13
14	Program Transportation							0				14
15	Other (specify):*							0				15
16	TOTAL Health Care and Progra	1,727,082	251,439	155,263	2,133,784	(353,592)	1,780,192	188,895	1,969,087			16
	C. General Administration											
17	Administrative	65,340			65,340		65,340	53,659	118,999			17
18	Directors Fees							4,071	4,071			18
19	Professional Services			433,978	433,978		433,978	(421,665)	12,313			19
20	Dues, Fees, Subscriptions & Promotions			138,542	138,542	(90,036)	48,506	(16,510)	31,996			20
21	Clerical & General Office Expense	213,084	14,389	11,746	239,219		239,219	198,481	437,700			21
22	Employee Benefits & Payroll Taxes			400,534	400,534		400,534	31,301	431,835			22
23	Inservice Training & Education			1,373	1,373		1,373	626	1,999			23
24	Travel and Seminar			4,047	4,047		4,047	(2,048)	1,999			24
25	Other Admin. Staff Transportation							0				25
26	Insurance-Prop.Liab.Malpractice			15,359	15,359		15,359	1,912	17,271			26
27	Other (specify):*			13,657	13,657		13,657	(13,249)	408			27
28	TOTAL General Administration	278,424	14,389	1,019,236	1,312,049	(90,036)	1,222,013	(163,422)	1,058,591			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,581,359	594,952	1,321,286	4,497,597	(443,628)	4,053,969	43,916	4,097,885			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			342,890	342,890		342,890	45,283	388,173			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			530,382	530,382		530,382	(1,307)	529,075			32
33	Real Estate Taxes			58,906	58,906		58,906	0	58,906			33
34	Rent-Facility & Grounds							11,637	11,637			34
35	Rent-Equipment & Vehicles			3,457	3,457		3,457	22,749	26,206			35
36	Other (specify):*							0				36
37	TOTAL Ownership			935,635	935,635		935,635	78,362	1,013,997			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers					353,592	353,592	0	353,592			39
40	Barber and Beauty Shops	0	356	0	356		356	0	356			40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee					90,036	90,036	0	90,036			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		356		356	443,628	443,984		443,984			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,581,359	595,308	2,256,921	5,433,588	0	5,433,588	122,278	5,555,866			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

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FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,852)	35		5
6	Rented Facility Space	(100)	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	35,663	30		9
10	Interest and Other Investment Income	(120)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,027)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(961)	20		17
18	Fines and Penalties				18
19	Entertainment	(11,386)	24		19
20	Contributions	(5,855)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,287)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(7,394)	27		24
25	Fund Raising, Advertising and Promotional	(20,721)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(857)	23		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (16,897)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in th general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	139,175		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 139,175		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 122,278		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

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ıe

Detail lines 29 and 35 of Page 5 starting in B44 DO NOT DRAG AND DROP CELLS.

The amounts in columns F will transfer to the Adj. Summary column automatically.

The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

Print Other Adjustments

STATE OF ILLINOIS **Page 5A**

Facility Name HERITAGE MANOR-NORMAL

IDH 0020281

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V Line	Adj. Summary
The information listed in B13 thru G43 is from Page 5.					
1	**Day Care**	0	0	**Line 1**	0
2	**Other Care for Outpatients**	0	0	**Line 2**	(1,852)
3	**Governmental Sponsored Special Programs**	0	0	**Line 3**	0
4	**Non-Patient Meals**	0	0	**Line 4**	0
5	**Telephone, TV & Radio in Resident Rooms**	(1,852)	35	**Line 5**	0
6	**Rented Facility Space**	(100)	34	**Line 6**	0
7	**Sale of Supplies to Non-Patients**	0		**Line 7**	0
8	**Laundry for Non-Patients**	0		**Line 8**	(1,852)
9	**Non-Straightline Depreciation**	35,663	30	**Line 9**	0
10	**Interest and Other Investment Income**	(120)	32	**Line 10**	0
11	**Discounts, Allowances, Rebates & Refunds**	0		**Line 10a**	0
12	**Non-Working Officer's or Owner's Salary**	0		**Line 11**	0
13	**Sales Tax**	(1,027)	2	**Line 12**	0
14	**Non-Care Related Interest**	0	32	**Line 13**	0
15	**Non-Care Related Owner's Transactions**	0		**Line 14**	0
16	**Personal Expenses (Including Transportation)**	0	24	**Line 15**	0
17	**Non-Care Related Fees**	(961)	20	**Line 16**	0
18	**Fines and Penalties**	0		**Line 17**	0
19	**Entertainment**	(11,386)	24	**Line 18**	0
20	**Contributions**	(5,855)	27	**Line 19**	(2,2[illegible]
21	**Owner or Key-Man Insurance**	0		**Line 20**	(21,682)
22	**Special Legal Fees & Legal Retainers**	(2,287)	19	**Line 21**	0
23	**Malpractice Insurance for Individuals**	0		**Line 22**	0
24	**Bad Debt**	(7,394)	27	**Line 23**	(857)
25	**Fund Raising, Advertising and Promotional**	(20,721)	20	**Line 24**	(11,386)
26	**Income & IL Personal Property Replacement T**	0	0	**Line 25**	0
27	**Nurse Aide Training for Non-Employees**	0	0	**Line 26**	0
28	**Yellow Page Advertising**	0	0	**Line 27**	(13,720)
29	**Non-Paid Workers**	0	0	**Line 28**	(49,441)
30	**Donated Goods**	0	0	**Line 29**	(70,440)
31	**Amortization Expense**	0	0	**Line 30**	35,663
32		(857)		**Line 31**	0
33				**Line 32**	(120)
34				**Line 33**	0
35				**Line 34**	(100)
36				**Line 35**	(1,852)
37				**Line 36**	0
38				**Line 37**	33,591
39				**Line 38**	0
40				**Line 39**	0
41				**Line 40**	0
42				**Line 41**	0
43				**Line 42**	0
44				**Line 43**	0
45				**Line 44**	0
46				**Line 45**	(16,777)

Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Numb HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	3,984	0	0	0	0	0	0	0	0	3,984	1
2	Food Purchase	(1,027)	0		0	0	0	0	0	0	0	0	(1,027)	2
3	Housekeeping	0	0		0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0		0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,388	0	0	0	0	0	0	0	0	1,388	5
6	Maintenance	0	0	14,098	0	0	0	0	0	0	0	0	14,098	6
7	Other (specify):*	0	0		0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,027)	0	19,470	0	0	0	0	0	0	0	0	18,443	8
	B. Health Care and Programs													
9	Medical Director	0	0		0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0		0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	(5,885)		0	191,305	0	0	0	0	0	0	185,420	10a
11	Activities	0	0		0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0		0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	3,475	0	0	0	0	0	0	0	0	3,475	13
14	Program Transportation	0	0		0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0		0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(5,885)	3,475	0	191,305	0	0	0	0	0	0	188,895	16
	C. General Administration													
17	Administrative	0	0	53,659	0	0	0	0	0	0	0	0	53,659	17
18	Directors Fees	0	0	4,071	0	0	0	0	0	0	0	0	4,071	18
19	Professional Services	(2,287)	0	12,313	0	(431,691)	0	0	0	0	0	0	(421,665)	19
20	Fees, Subscriptions & Promotions	(21,682)	0	5,172	0	0	0	0	0	0	0	0	(16,510)	20
21	Clerical & General Office Expenses	0	0	198,481	0	0	0	0	0	0	0	0	198,481	21
22	Employee Benefits & Payroll Taxes	0	0	31,301	0	0	0	0	0	0	0	0	31,301	22
23	Inservice Training & Education	(857)	0	1,483	0	0	0	0	0	0	0	0	626	23
24	Travel and Seminar	(11,386)	0	9,338	0	0	0	0	0	0	0	0	(2,048)	24
25	Other Admin. Staff Transportation	0	0		0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,912	0	0	0	0	0	0	0	0	1,912	26
27	Other (specify):*	(13,249)	0	0	0	0	0	0	0	0	0	0	(13,249)	27
28	**TOTAL General Administration**	(49,461)	0	317,730	0	(431,691)	0	0	0	0	0	0	(163,422)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(50,488)	(5,885)	340,675	0	(240,386)	0	0	0	0	0	0	43,916	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Numb: HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	35,663	0	0	9,620	0	0	0	0	0	0	0	45,283	30
31	Amortization of Pre-Op. & Org.	0	0	0		0	0	0	0	0	0	0	0	31
32	Interest	(120)	0	0	(1,187)	0	0	0	0	0	0	0	(1,307)	32
33	Real Estate Taxes	0	0	0		0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(100)	0	0	11,737	0	0	0	0	0	0	0	11,637	34
35	Rent-Equipment & Vehicles	(1,852)	0	0	24,601	0	0	0	0	0	0	0	22,749	35
36	Other (specify):*	0	0	0		0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	33,591	0	0	44,771	0	0	0	0	0	0	0	78,362	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Cent**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(16,897)	(5,885)	340,675	44,771	(240,386)	0	0	0	0	0	0	122,278	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Numbe HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning 01/01/00 Ending 12/31/00

Show Pgs 6A thru 6 | Show Pgs 6E thru 6 | Hide Pgs 6A thru 6

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V							1
2	V	10z Adjustment for Related Organizati	112,784	GreenTree Therapy	100.00%	106,899	(5,885)	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		$ 112,784			$ 106,899	$ * (5,885)	14

Sum_6

-5885

* Total must agree with the amount recorded on line 34 of Schedule V

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1 Line 2 Line 3 Line 4 Line 5 Line 6 Line 7 Line 9 Line 10 Line 10a Line 11 Line 12 Line 13 Line 14 Line 15 Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 30 Line 31 Line 32 Line 33 Line 34 Line 35 Line 36 Line 38 Line 39 Line 40 Line 41 Line 42 Line 43

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SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginnin 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	1	Dietary	$	Heritage Enterprises, Inc.	100.00%	$ 3,984	$ 3,984	15	3984
16	V	2	Food Purchase				0		16	
17	V	3	Housekeeping				0		17	
18	V	4	Laundry				0		18	
19	V	5	Heat & Other Utilities				1,388	1,388	19	1388
20	V	6	Maintenance				14,098	14,098	20	14098
21	V	7	Other				0		21	
22	V	9	Medical Director				0		22	
23	V	10	Nursing & Medical Records				0		23	
24	V	11	Activities				0		24	
25	V	12	Social Service				0		25	
26	V	13	Nurse Aide Training				3,475	3,475	26	3475
27	V	14	Program Transportatior				0		27	
28	V	15	Other				0		28	
29	V	17	Administrative				53,659	53,659	29	53659
30	V	18	Directors Fees				4,071	4,071	30	4071
31	V	19	Professional Services				12,313	12,313	31	12313
32	V	20	Fees, Subscription, Promotions				5,172	5,172	32	5172
33	V	21	Clerical & General Office Expenses				198,481	198,481	33	198481
34	V	22	Employee Benefits & Payroll Taxes				31,301	31,301	34	31301
35	V	23	Inservice Training & Education				1,483	1,483	35	1483
36	V	24	Travel and Seminar				9,338	9,338	36	9338
37	V	25	Other Admin. Staff Transportatior				0		37	
38	V	26	Insurance-Prop.Liab.Malpract				1,912	1,912	38	1912
39	Total			$			$ 340,675	$ * 340,675	39	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

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Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginnin 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6B
15	V	27	Other	$	Heritage Enterprises, Inc.	100.00%	$ 0	$	15	
16	V	30	Depreciation				9,620	9,620	16	9620
17	V	31	Amortization of Pre-Op & Org				0		17	
18	V	32	Interest				(1,187)	(1,187)	18	-1187
19	V	33	Real Estate Taxes				0		19	
20	V	34	Rent-Facility & Grounds				11,737	11,737	20	11737
21	V	35	Rent-Equipment & Vehicles				24,601	24,601	21	24601
22	V	36	Other				0		22	
23	V	38	Medically Nec Transportation				0		23	
24	V	39	Ancillary Service Centers				0		24	
25	V	40	Barber and Beauty Shops				0		25	
26	V	41	Coffee and Gift Shops				0		26	
27	V	42	Other				0		27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$			$ 44,771	$ * 44,771	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

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DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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Print Page 6

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STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginnin 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6C
15	V	19	Adjustment for Related Organizatio	$ 431,691	Heritage Enterprises, Inc.		$	$ (431,691)	15	-431691
16	V								16	
17	V	10a	Adjustment for Related Organizatior	161,399	Green Tree Pharmacy	100.00%	352,704	191,305	17	191305
18	V								18	
19	V								19	
20	V								20	
21	V								21	
22	V								22	
23	V								23	
24	V								24	
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 593,090			$ 352,704	$ * (240,386)	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

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Print Page 6

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STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginnin 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

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Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginnin 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bill Froelich	Chairman of Boarc	Management	0.26	17,872	10	0.20	Directors Fe	$ 1,358	line 18, col 7	1
2	Tom Jefferson	Asst Secretary/Tre	Management	0.10	17,873	10	0.20	Directors Fees	1,357	line 18, col 7	2
3	Craig Hart	Secretary/Treasure	Management	0.20	17,873	10	0.20	Directors Fees	1,357	line 18, col 7	3
4	Bill Froelich	Chairman of Boarc	Management	0.26	127,797	10	0.20	Salary	9,703	line 17, col 7	4
5	Tom Jefferson	Asst Secretary/Tre	Management	0.10	127,797	10	0.20	Salary	9,703	line 17, col 7	5
6	Craig Hart	Secretary/Treasure	Management	0.20	105,832	10	0.20	Salary	8,035	line 17, col 7	6
7	Joe Warner	President	Management	0.03	99,880	48	0.95	Salary	7,583	line 17, col 7	7
8	Bob Dickson	Executive Vice Pre	Management	0.01	65,076	50	1.00	Salary	4,941	line 17, col 7	8
9	Cheryl Lowney	Executive Vice Pre	Management	0.00	53,609	50	1.00	Salary	4,070	line 17, col 7	9
10	Steve Wannemacher	Executive Vice Pre	Management	0.00	53,338	50	1.00	Salary	4,050	line 17, col 7	10
11	Connie Hoselton	Sr Vice President	Management	0.00	32,927	40	1.00	Salary	2,500	line 17, col 7	11
12	Craig Ater	Sr Vice President	Management	0.00	40,480	50	1.00	Salary	3,073	line 17, col 7	12
13								TOTAL	$ 57,730		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Print Previe

the name(s)
PORTS.

Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT C

Show Pgs 8A thru 8 | Show Pgs 8E thru 8 | Hide Pgs 8A thru 8

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizatio: Heritage Enterprises
Street Address: 115 W. Jefferson
City / State / Zip Code: Bloomington, Il 61701
Phone Number: (309) 823-7135
Fax Number: (309) 829-5477

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	BEDS	2,324	23	$ 56,457	$ 56,457	164	$ 3,984	1
2	2	Food Purchase	BEDS	2,324	23	6	0	164	0	2
3	3	Housekeeping	BEDS	2,324	23	0	0	164	0	3
4	4	Laundry	BEDS	2,324	23	0	0	164	0	4
5	5	Heat & Other Utilities	BEDS	2,324	23	19,665	0	164	1,388	5
6	6	Maintenance	BEDS	2,324	23	199,772	50,885	164	14,098	6
7	7	Other	BEDS	2,324	23	0	0	164	0	7
8	9	Medical Director	BEDS	2,324	23	0	0	164	0	8
9	10	Nursing & Medical Records	BEDS	2,324	23	0	0	164	0	9
10	11	Activities	BEDS	2,324	23	0	0	164	0	10
11	12	Social Service	BEDS	2,324	23	0	0	164	0	11
12	13	Nurse Aide Training	BEDS	2,324	23	49,237	43,081	164	3,475	12
13	14	Program Transportation	BEDS	2,324	23	0	0	164	0	13
14	15	Other	BEDS	2,324	23	0	0	164	0	14
15	17	Administrative	BEDS	2,324	23	760,393	760,393	164	53,659	15
16	18	Directors Fees	BEDS	2,324	23	57,693	0	164	4,071	16
17	19	Professional Services	BEDS	2,324	23	174,483	0	164	12,313	17
18	20	Fees, Subscription, Promotion	BEDS	2,324	23	73,288	0	164	5,172	18
19	21	Clerical & General Office Exp	BEDS	2,324	23	2,812,617	2,533,181	164	198,481	19
20	22	Employee Benefits & Payroll	BEDS	2,324	23	443,562	0	164	31,301	20
21	23	Inservice Training & Educati	BEDS	2,324	23	21,017	0	164	1,483	21
22	24	Travel and Seminar	BEDS	2,324	23	132,330	0	164	9,338	22
23	25	Other Admin. Staff Transpor	BEDS	2,324	23	0	0	164	0	23
24	26	Insurance-Prop.Liab.Malprac	BEDS	2,324	23	27,096	0	164	1,912	24
25	TOTALS					$ 4,827,616	$ 3,443,997		$ 340,675	25

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STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	BEDS	2,324	23	$ 0	$ 0	164	$ 0	1
2	30	Depreciation	BEDS	2,324	23	136,322	0	164	9,620	2
3	31	Amortization of Pre-Op & Or	BEDS	2,324	23	0	0	164	0	3
4	32	Interest	BEDS	2,324	23	(16,821)	0	164	(1,187)	4
5	33	Real Estate Taxes	BEDS	2,324	23	0	0	164	0	5
6	34	Rent-Facility & Grounds	BEDS	2,324	23	166,328	0	164	11,737	6
7	35	Rent-Equipment & Vehicles	BEDS	2,324	23	348,617	0	164	24,601	7
8	36	Other	BEDS	2,324	23	0	0	164	0	8
9	38	Medically Nec Transportation	BEDS	2,324	23	0	0	164	0	9
10	39	Ancillary Service Centers	BEDS	2,324	23	0	0	164	0	10
11	40	Barber and Beauty Shops	BEDS	2,324	23	0	0	164	0	11
12	41	Coffee and Gift Shops	BEDS	2,324	23	0	0	164	0	12
13	42	Other	BEDS	2,324	23	0	0	164	0	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 634,446	$		$ 44,771	25

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Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	LaSalle National Bank		XX	Mortage	16000 plus int	01/15/99	$ 5,352,345	$ 5,130,934	01/15/06	0.0875	$ 477,673	1
2	LaSalle Loan Amortization		XX	Mortgage							5,359	2
3	Central Office Allocation		XX	Interest Income							(1,187)	3
4												4
5												5
	Working Capital											
6												6
7	National City working Capital										47,350	7
8												8
9	TOTAL Facility Related						$ 5,352,345	$ 5,130,934			$ 529,195	9
	B. Non-Facility Related*											
10	Interest Income										(120)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,352,345	$ 5,130,934			$ 529,075	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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Facility Name & ID Numbe HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	69,197	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	62,489	2
3. Under or (over) accrual (line 2 minus line 1).	$	(6,708)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	65,614	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	58,906	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995	50,411	8
1996	53,400	9
1997	58,759	10
1998	57,580	11
1999		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

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Facility Name & ID Numb HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,800 B. General Construction Type: Exterior Brick/Wood Frame _____ Number of Stories _____

C. Does the Operating Entity? [XX] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home		1979	$ 150,000	1
2	Nursing Home				2
3	TOTALS			$ 150,000	3

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12 | Show Pgs 12C and 12 | Hide Pgs 12A thru 12

STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	164				$ 1,860,193	$		$	$	$	4
5					0						5
6											6
7											7
8											8
	Improvement Type**										
9	1979 Improvements			1979	64,594						9
10	1980 Improvements			1980	48,089						10
11	1981 Improvements			1981	17,747						11
12	1982 Improvements			1982	18,009						12
13	1983 Improvements			1983	19,892						13
14	1984 Improvements			1984	25,484						14
15	1985 Improvements			1985	531,851						15
16	1986 Improvements			1986	82,460						16
17	1987 Improvements			1987	17,447						17
18	1988 Improvements			1988	133,532						18
19	1989 Improvements			1989	39,555						19
20	1990 Improvements			1990	18,557						20
21	1991 Improvements			1991	5,776						21
22	1992 Improvements			1992	8,016						22
23	1993 Improvements			1993	188,048						23
24	1994 Improvements			1994	187,325						24
25	1995 Improvements			1995	10,664						25
26	A/C Basement Laundry			1996	6,741						26
27	Asphalt Repair			1996	21,401						27
28	Remodel/Painting			1996	1,912						28
29	Fire Alarm Repair/Replace			1996	8,069						29
30	Kitchen Floor/Backsplash			1996	1,395						30
31											31
32											32
33											33
34	C/O Allocation							9,620	9,620		34
35	Book Depreciation					241,965		278,473	36,508	2,683,975	35
36	TOTAL (lines 4 thru 35)				$ 3316756.8	$ 241,965		$ 288,093	$ 46,128	$ 2,683,975	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Facility Name & ID Numbe HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Tubes--Boiler			1997	12,279						9
10	Smoke Damper			1997	2,508						10
11	Perimeter Alarm			1997	3,364						11
12	Door Alarm			1997	3,909						12
13	Parking Lot Lights			1997	1,221						13
14	Fire Door			1997	2,146						14
15											15
16	Asbestos Removel			1998	985						16
17	Fire Daper			1998	4,589						17
18	Plumbing Maintenance			1998	3,285						18
19	HVAC Repairs			1998	2,139						19
20	Boiler Retubed			1998	5,720						20
21	Remodel Resident Rooms and Halls-materials			1998	739,117						21
22	Remodel Resident Rooms and Halls- Labor			1998	4,323						22
23	Remodel Resident Rooms and Halls-Professional Fees			1998	38,935						23
24											24
25	Moving Furnature Expense			1998	6,398						25
26	Computer Room Work			1998	896						26
27	Alzheimers Addition-Materials			1998	876,511						27
28	Alzheimers Addition-Labor			1998	516						28
29	Alzheimers Addition-Professional Fees			1998	162,266						29
30	Ventalation System-Materials			1998	54,231						30
31	Ventalation System-Professional Fees			1998	33,010						31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Facility Name & ID Numbe HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Alzheimers Addition-Materials			1999	1,913,384						9
10	Alzheimers Addition-Labor			1999	16,393						10
11	Alzheimers Addition-Professional Fees			1999	43,955						11
12	Ventalation System-Materials			1999	2,591						12
13	Remodel Resident Rooms--Materials			1999	96,197						13
14	Remodel Resident Rooms--Professional Fees			1999	350						14
15	Patio Replacement			1999	3,700						15
16	WAN Room Renovation			1999	3,230						16
17	ALTA Survey			1999	5,488						17
18	PANIC Hardware			1999	1,941						18
19	Roof Work			1999	4,844						19
20	Boiler Replacement			1999	11,219						20
21	Garage Door			1999	985						21
22	West End Renovations-Labor			1999	2,184						22
23	Assisted Living Professional Fees			1999	1,843						23
24											24
25	West Wing Outlets			2000	8,485						25
26	Alzheimer Unit Flooring			2000	5,631						26
27	Accordian Door and Installation			2000	9,600						27
28	Air conditioning Units (2)			2000	1,240						28
29	Exterior Door Replacement			2000	6,095						29
30	Air conditioner -- Dishroom			2000	12,041						30
31	HVAC temp Control			2000	16,220						31
32	Mop sink and faucet (2)			2000	3,377						32
33	Clinical Sink			2000	847						33
34	Eye Wash Stations			2000	2,566						34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Facility Name & ID Numbe HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	West End Renovations-Labor			2000	9,940						9
10	West End Renovations-material			2000	7,991						10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Facility Name & ID Numbe HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
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29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 1,044,915	$ 100,925	$ 100,080	$ (845)		$ 564,715	37
38	Current Year Purchases	6,598						38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 1,051,513	$ 100,925	$ 100,080	$ (845)		$ 564,715	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 342,890	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 388,173	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 45,283	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 3,248,690	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the curre rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipm $ 26,206 Description: Copier, Cell Phone and Central Office Allocation
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- COMMUNITY COLLEGE ☐
- HOURS PER AIDE ___

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- HOURS PER AIDE ___

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		1,284		1,284
3	Classroom Wages (a)		2,862		2,862
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		3,475		3,475
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 7,621	$	$ 7,621
10	SUM OF line 9, col. 1 and 2 (e)	$ 7,621			

C. CONTRACTUAL INCOME

In the box below record the amount of income y facility received training aides from other faciliti

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a/3	hrs	$	689	$ 28,879	$	689	$ 28,879	1
2	Licensed Speech and Language Development Therapist	10a/3	hrs		131	7,563		131	7,563	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a/3	hrs		1,726	70,457	167	1,726	70,624	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/3	# of prescrpts				352,697		352,697	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab	39/3				895			895	13
14	TOTAL			$	2,546	$ 107,794	$ 352,864	2,546	$ 460,658	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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pt adj	-7921
st adj	3211
Ot adj	-1175
drugs	191306

Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 300	$	1
2	Cash-Patient Deposits	11,651		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	417,039		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,345		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(592,130)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (138,795)	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	181,333		13
14	Buildings, at Historical Cost	7,133,969		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,113,895		16
17	Accumulated Depreciation (book methods)	(1,897,173)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	30,619		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 6,562,643	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,423,848	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 47,109	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,651		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	277,045		30
31	Accrued Taxes Payable (excluding real estate taxes)	791		31
32	Accrued Real Estate Taxes(Sch.IX-B)	65,614		32
33	Accrued Interest Payable	36,945		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		1,230		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 440,385	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	5,130,934		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,130,934	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,571,319	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 856,943	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,428,262	$	48

***(See instructions.)**

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Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 848,647	1
2	Restatements (describe):		2
3	audit Adjustment	36,801	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 885,448	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(28,505)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (28,505)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 856,943	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,366,380	1
2	Discounts and Allowances for all Levels	(463,069)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,903,311	3
	B. Ancillary Revenue		
4	Day Care	0	4
5	Other Care for Outpatients		5
6	Therapy	171,153	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 171,153	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	8,821	11
12	Gift and Coffee Shop	8,566	12
13	Barber and Beauty Care	3,278	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	100	16
17	Sale of Drugs	310,262	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(528)	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thr**	$ 330,499	23
	D. Non-Operating Revenue		
24	Contributions	0	24
25	Interest and Other Investment Income***	120	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and**	$ 120	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	other	0	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 2**	$ 5,405,083	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 1,051,764	31
32	Health Care	2,133,784	32
33	General Administration	1,312,049	33
	B. Capital Expense		
34	Ownership	935,635	34
	C. Ancillary Expense		
35	Special Cost Centers	356	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,433,588	40
41	**Income before Income Taxes (line 30 minus line 40)****	(28,505)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus**	$ (28,505)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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Facility Name & ID Number HERITAGE MANOR-NORMAL # 0038281 Report Period Beginning 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,960	1,976	$ 45,896	$ 23.23	1
2	Assistant Director of Nursing	2,062	2,356	38,958	16.54	2
3	Registered Nurses	23,040	24,556	459,092	18.70	3
4	Licensed Practical Nurses	20,428	22,138	331,188	14.96	4
5	Nurse Aides & Orderlies	74,752	78,417	708,531	9.04	5
6	Nurse Aide Trainees	200	200	2,862	14.31	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,290	4,630	45,765	9.88	8
9	Activity Director					9
10	Activity Assistants	5,829	6,251	43,965	7.03	10
11	Social Service Workers	2,688	2,889	50,825	17.59	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	36,175	38,490	271,101	7.04	15
16	Dishwashers					16
17	Maintenance Workers	14,051	15,642	114,675	7.33	17
18	Housekeepers	14,902	15,511	96,039	6.19	18
19	Laundry	12,487	13,229	94,038	7.11	19
20	Administrator	2,080	2,080	65,340	31.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,433	17,726	213,084	12.02	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	231,377	246,091	$ 2,581,359 *	$ 10.49	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

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B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director		3,000		36
37	Medical Records Consultant		975		37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,180		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		827		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 7,982		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0		50
51	Licensed Practical Nurses		0		51
52	Nurse Aides		29,983		52
53	TOTAL (lines 50 - 52)		$ 29,983		53